New Mexico Medical Board
2055 S. Pacheco Street, Building 400
Santa Fe, NM 87505
505-476-7220
Fax: 505-476-7233

Susana Martinez
Governor

Steven Weiner, MD
Chair

ADDITIONAL PHYSICIAN INFORMATION

Physician Name: Kumar (Last) Bhavik (First) (Middle)

An asterisk (*) indicates that this information will be kept confidential.

Will you be applying by endorsement? Yes ☐ No ☑	**Citizenship:** USA
Immigration Status:	**INS Certification #:** N/A ☐
***Fed Tax ID#:** Pending ☐ N/A ☑	***NM Tax ID#:** Pending ☑ N/A ☐
***Fed. Drug Enforcement Admin. (DEA) Registration #:** [redacted]	**Exp. Date:** 12/31/2015 Pending ☐ N/A ☐
***State Controlled Substance Registration (CSR)#** **State:** **Exp. Date:**	Pending ☐ N/A ☐
***Medicare Unique Physician Identification Number (UPIN):**	Pending ☐ N/A ☑
***State Medicaid Provider Number:** **State:**	Pending ☐ N/A ☑

PRACTICE INFORMATION -- Please list all applicable practice information below.

Current Practice Name: Whole Woman's Health	
Street Address: 4025 EAST SOUTHCROSS BLVD. BLDG 5, STE 30	
City: San Antonio **State:** TX **Zip Code:** 78222	
Telephone Number: 210-549-4084	**Facsimile Number:**
***Office Manager or Contact Person:** Marva Sadlet	**Practice Limited to (clinical specialty):**
Foreign Languages (spoken fluently by practitioner): Spanish	
Foreign Languages (spoken fluently at Practice):	
What are your immediate or future Practice Plans in New Mexico?	
Practice Associates in NM (if applicable): Linda Prine	
Call Coverage in NM (if applicable):	
Other Practice Locations (if applicable):	
Other Practice Name:	
Street Address:	
City: **State:** **Zip Code:**	
Telephone Number:	**Facsimile Number:**
Answering Service:	**Effective Date:**

Applicant Name: _____

PROFESSIONAL REFERENCES – Please list three professional peers familiar with your professional performance in the past 5 years (not including current or impending partners or associates in practice).

(1) Name and Title: Mary Duggan, MD			
Street Address: 3544 Jerome Ave			
City: Bronx		**State:** NY	**Zip Code:** 10467
Telephone Number: 718 933 2400		**Facsimile Number:** 718.515.5416	

(2) Name and Title: Marji Gold, MD			
Street Address: 3544 Jerome Ave			
City: Bronx		**State:** NY	**Zip Code:** 10467
Telephone Number: 718 933 2400		**Facsimile Number:** 718.515.5416	

(3) Name and Title: Tara Stein			
Street Address: 3544 Jerome Ave			
City: Bronx		**State:** NY	**Zip Code:** 10467
Telephone Number: 718 933 2400		**Facsimile Number:** 718.515.5416	

SPECIALTY BOARD CERTIFICATIONS ☐ N/A **Are you Board Certified?** ☑ Yes ☐ No

Note: If you are not Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association, the National Commission on Certification of Physician Assistants, the American Nurses' Credentialing Center, or the National Certification Commission, or accepted for examination in your specialty, please give a brief explanation on an attached sheet.

Certified/Recertified by the: American Board of Family Medicine		
Date Certified: 06/2013	**Date Last Recertified:**	**Exp. Date:** 2023
Certified/Recertified by the:		
Date Certified:	**Date Last Recertified:**	**Exp. Date:**
Accepted for Examination by the:		
Until (expiration date):	**If not accepted, have you made application?** ☐ Yes ☐ No	

Certified/Recertified by the Subspecialty Board of:		
Date Certified:	**Date Last Recertified:**	**Exp. Date:**
Certified/Recertified by the Subspecialty Board of:		
Date Certified:	**Date Last Recertified:**	**Exp. Date:**
Accepted for Examination by the Subspecialty Board of:		
Until (expiration date):	**If not accepted, have you made application?** ☐ Yes ☐ No	

PROFESSIONAL LIABILITY INSURANCE*

Do you have current liability insurance? ☑ Yes ☐ No ☐ Pending	**Current Carrier:** Landmark American Insurance Compa	
Complete address: Care of Marsh & McLennan Agency LLC, One Executive Drive, Somerset NJ, 08873		
Dates Insured **From:** 12/1/2014 **To:** 9/15/2016	**Policy #:** [redacted]	**Coverage Limits:** [redacted]

Applicant Name: _____

Uniform Application for Physician Licensure

UA Username Bkumar3201
FCVS Status No FCVS Packet

Date Submitted 8/18/2015

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name Kumar
First Name Bhavik
Middle Name
Suffix
Maiden Name
M.D. [X] **D.O.** [ ]

All other names used

First	Middle	Last	Suffix

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

2. Address/Phone

Business
[X] **Public Access**
[ ] **Mailing**

Street 3900 Lohman Ave
Ste B
City Las Cruces **State/Province** NM **Zip Code** 88011
Country USA
Telephone 5755223122
Fax
Email drkumar@wholewomanshealth.com
Alternate Phone

Home
[ ] **Public Access**
[X] **Mailing**

Street [redacted]
City [redacted] **State/Province** TX **Zip Code** 78701
Country
Telephone
Fax
Email drkumar@wholewomanshealth.com
Alternate Phone

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

[redacted]1985	London		United Kingdom
Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country

M	[redacted]	1003197641		
Gender	Social Security Number	NPI	Are you a U.S. Citizen?	[X] Yes [ ] No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, please go to http://www.cms.hhs.gov/NationalProvidentStand/.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School

1 **School Name** Texas Tech University Health Sciences Center School of Medicin
Address 3601 4th Street

City Lubbock
State/Province TX
ZIP Code 79430
Country USA
Attendance Dates **From (mm/yyyy)** 07/2006 **To (mm/yyyy)** 06/2010
Graduation Date 6/1/2010
Degree DM

5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

Medical School Name			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Graduation Date			
Degree			
Institution name where rotations performed			
Address			
City			
State/Province			
ZIP Code			
Country			
Rotation Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Certification Date			

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training

1

Hospital Name Montefiore Medical Center
Hospital Address 111 E 210th Street

City Bronx
State/Province New York
ZIP Code 10467
Country USA

PGY: (e.g., 1, 2, 3, etc.) ☐ **Internship** ☒ **Residency** ☐ **Fellowship** ☐ **Research** ☐ **Other**

Department/Specialty Family & Social Medicine

From: 07 /2010 **To:** 06 /2013 **Successfully Completed?** ☒ **Yes** ☐ **No** **In Progress** ☐

Month Year Month Year

2

Hospital Name Albert Einstein COM
Hospital Address 3544 Jerome Ave

City Bronx
State/Province New York
ZIP Code 19467
Country

PGY: (e.g., 1, 2, 3, etc.) ☐ **Internship** ☐ **Residency** ☒ **Fellowship** ☐ **Research** ☐ **Other**

Department/Specialty Family & Social Medicine/Family Planning

From: 07 /2013 **To:** 07 /2015 **Successfully Completed?** ☒ **Yes** ☐ **No** **In Progress** ☐

Month Year Month Year

7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step 1		06/2008	[X] P	[ ] F	1
USMLE Step 2		07/2009	[X] P	[ ] F	1
USMLE Step2 CS		07/2009	[X] P	[ ] F	1
USMLE Step 3		11/2011	[X] P	[ ] F	1

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG web site at www.ecfmg.org.

8. ECFMG (if applicable)		
Certificate Number	Issue Date	Valid Through Date

9. State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure

1	**State/Province**	NY	**Practitioner Type** (MD, DO, etc.)	MD	**Type of License** (Full, Temporary, etc.)	Full License	
	License Number	269339	**Status**	Active	**Issue Date**	3/22/2013	
2	**State/Province**	TX	**Practitioner Type** (MD, DO, etc.)	MD	**Type of License** (Full, Temporary, etc.)	Full License	
	License Number	Q2321	**Status**	Active	**Issue Date**	11/7/2014	

10. Chronology of Activities: List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM**. Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities

Dates: From/To	Practice/Employment
1 From: Month: 07 Year: 2010 To: Month: 06 Year: 2013 In Progress ☐	**Practice/Employment Name** Montefiore Medical Center (or list non-working time as indicated above) **Practice/Employment Address** 111 E 210th Street **City** Bronx **State/Province** New York **ZIP Code** 10467 **Country** USA **Position and Department** Resident-Family & Social Medicine **Percent Clinical:** 90% **Percent Administrative:** 10% **Employment** ☐ **Staff Privileges** ☒ **Affiliation** ☐ **Other**
2 From: Month: 07 Year: 2013 To: Month: 07 Year: 2013 In Progress ☐	**Practice/Employment Name** (or list non-working time as indicated above) **Practice/Employment Address** **City** **State/Province** **ZIP Code** **Country** **Position and Department** **Percent Clinical:** 0% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**
3 From: Month: 07 Year: 2013 To: Month: 07 Year: 2015 In Progress ☐	**Practice/Employment Name** Albert Einstein COM (or list non-working time as indicated above) **Practice/Employment Address** 3544 Jerome Ave 2nd Floor **City** Bronx **State/Province** New York **ZIP Code** 10467 **Country** USA **Position and Department** Fellow-Family and Social Medicine **Percent Clinical:** 40% **Percent Administrative:** 60% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
4 From: Month: 07 Year: 2015 To: Month: Year: In Progress ☒	**Practice/Employment Name** Whole Woman's Health (or list non-working time as indicated above) **Practice/Employment Address** 4025 East Southcross BLVD Bldg. 5, Ste. 30 **City** San Antonio **State/Province** Texas **ZIP Code** 78222 **Country** USA **Position and Department** Attending physician-Clinical care **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☒ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

11. Malpractice: List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please have your information available before reviewing this section and contact the state board or FCVS to make changes.

11. Malpractice Liability Claims Information

Name of patient involved:

In which state did the action take place? **Case number (if applicable)**

Which court?
(If private compromise or settled before initiation of civil action, state here)

Current status of claim:

☐ Open (pending) ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Amount of judgement or settlement $ **Amount paid on your behalf $**

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/or was your status? ☐ **Primary defendant** ☐ **Co-defendant** ☐ **Other**

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

Federation of STATE MEDICAL BOARDS

Federation of State Medical Boards

UA Summary of Reported Board Actions

Physician Identification

Name: **Bhavik Kumar**
Alternate Names: [redacted]
DOB: [redacted]1985
Medical School: **Texas Tech University Health Sciences Center School of Medicine**

Year of Graduation: 2010

Summary of Reported Board Actions

No Reportable Board Actions Found

Reportable Actions as of UA Submission Date : 08/18/2015
UA Submission ID : 91,055
UA User Name : Bkumar3201

Federation of State Medical Boards
UA Licensure History

Physician Identification

Name:	Bhavik Kumar
Alternate Names:	
DOB:	[redacted]1985
Medical School:	Texas Tech University Health Sciences Center School of Medicine
Year of Graduation:	2010

Licensure History

State Board/Licensing Entity	License Number	Issue Date	Expiration Date
Texas Medical Board	Q2321	11/07/2014	11/30/2015
New York State Board for Medicine	269339	03/22/2013	12/31/2016
Texas Medical Board	BP10045440	03/20/2013	04/08/2013
Texas Medical Board	44193		

Licensure History as of UA Submission Date: 08/18/2015
UA Submission ID: 91055
UA User Name: Bkumar3201

PROFESSIONAL PRACTICE QUESTIONS – Please answer all of the following Yes or No questions. If you answer YES to any question, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

1.	Has your professional liability coverage ever been terminated by action of the insurance company except as a result of the company ceasing to offer insurance to physicians?	Yes ☐ No ☑
2.	Have you ever been denied professional liability insurance coverage?	Yes ☐ No ☑
3.	Has your professional liability carrier ever excluded any specific procedures from your coverage?	Yes ☐ No ☑
4.	Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization?	Yes ☐ No ☑
5.	Have you ever been excluded from or sanctioned by Medicare and/or Medicaid?	Yes ☐ No ☑
6.	Have you ever been arrested? If so explain the circumstance, regardless of the outcome (i.e. expunged, dismissed, sealed, vacated).	Yes ☐ No ☑
7.	Have you ever been named as a defendant in any criminal proceedings?	Yes ☐ No ☑
8.	Have you ever been subject to investigation by a governmental entity or Board that either could have resulted or did result in licensure sanction or other adverse actions, irrespective of the outcome?	Yes ☐ No ☑
9.	Have you ever been named in any formal requests for corrective actions filed by any healthcare entity where you have had an appointment (a request which could result in either formal or informal proceedings).	Yes ☐ No ☑
10.	**a.** Have your privileges at any healthcare entity ever been voluntarily or involuntarily suspended, restricted, diminished, revoked, surrendered, or not renewed, except for medical records delinquency? **b.** Have you ever agreed not to exercise your clinical privileges while under investigation?	Yes ☐ No ☑ Yes ☐ No ☑
11.	Have you ever resigned from a healthcare entity to avoid modification, suspension, or termination of privileges, or while under investigation?	Yes ☐ No ☑
12.	**a.** Has your application for licensure or license to practice in any jurisdiction ever been investigated, voluntarily or involuntarily limited, suspended, revoked, surrendered or denied? **b.** Are any currently held licenses pending investigation or being challenged?	Yes ☐ No ☑ Yes ☐ No ☑
13.	Have you ever been notified to appear before any licensing agency for a hearing or complaint of any nature?	Yes ☐ No ☑
14.	Has your federal or state narcotics registration certificate in any jurisdiction ever been voluntarily or involuntarily limited (stipulations), suspended, revoked, restricted, or are there currently challenges to any of these items?	Yes ☐ No ☑
15.	Have you ever been involved in a settlement, medical malpractice claim or suit, or have you ever received written notice of intent to file such a suit? **If yes, complete the Malpractice Liability Claims Information page in the online UA. Include the following information in the specifics area:** • Name, age, sex of patient/claimant. • Nature of allegations in claims/suits. Specify whether a suit was ever filed. • Names of other practitioners and hospital, if any, involved in claims or suit. • Name of defense attorney.	Yes ☐ No ☑

Applicant Name: _____

16.	Have you ever been reported to the National Practitioner Data Bank?	Yes ☐ No ☑
17.	**a.** Are you now, or were you in the past, addicted to, abusive of, or in treatment for abuse of any controlled substances, habit-forming drugs, illegal drugs, prescription medication or alcohol? **b.** Are you being treated with opiates for chronic pain? **If yes, please provide to the Board upon application a current evaluation from your treating pain provider (MD or DO).**	Yes ☐ No ☑ Yes ☐ No ☑
18.	In the five (5) years prior to this application, have you had any physical injury or disease, or mental illness or impairment, which you are currently under treatment for or could reasonably be expected to affect your on-going ability to practice medicine safely and competently? **If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis and treatment.**	Yes ☐ No ☑
19.	Have you ever, for any reason: **a.** Resigned from a medical school or postgraduate training (PGT) program? **b.** Withdrawn from a medical school or postgraduate training program? **c.** Been suspended, dismissed, or expelled from a medical school or PGT program? **d.** Been placed on probation or remediation, including academic probation or remediation, by a medical school or PGT program? **e.** Taken a leave of absence or break from, or had any interruptions or extensions in, a medical school or PGT program for any personal or professional reason (including illness or disability, pregnancy or maternity, any academic issue, etc)?	 Yes ☐ No ☑ Yes ☐ No ☑ Yes ☐ No ☑ Yes ☐ No ☑ Yes ☐ No ☑
20.	I attest that I will limit my practice to areas in which I am competent to practice.	Yes ☑ No ☐

If you answer YES to any question except for Question 20, please give details including name, address, and telephone number of significant parties on a separate sheet of paper.

Applicant Name: _____

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Affidavit and Authorization for Release of Information

Applicant: Follow the instructions in the left sidebar.
Send this to the state board you are applying to for licensure, NOT to FCVS/FSMB.

Applicant:

This is a separate form from the FCVS affidavit and release.

If you are using FCVS, you must complete both FCVS and UA affidavits. Send the FCVS affidavit to FCVS.

Sign this form with attached photo in the presence of a notary public.

Send this notarized affidavit to the board you are applying to for licensure. See http://www.fsmb.org/policy/contacts for a directory of state medical boards.

DO NOT SEND THIS FORM TO FCVS/FSMB. Doing so will delay your licensure process.

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

Bhavik Kumar
Applicant's signature (must be signed in the presence of a notary)

KUMAR
Applicant's printed last name

BHAVIK
Applicant's printed first name, middle initial, and suffix (e.g., Jr.)

9/19/2015
Date of signature (must correspond to date of notarization)

fold up — fold up

After folding the bottom portion upward, bring the new bottom edge to the top edge and fold to fit in a standard envelope.

Notary

State of Texas, County of Tarrant

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this 19 day of September, 2015.

Notary Public Signature: K. Ramos

My Notary Commission Expires: April 08, 2017

(NOTARY PUBLIC SEAL)
KAREEN RAMOS
Notary Public, State of Texas
My Commission Expires
April 08, 2017

AMA Physician Profile

PREPARED FOR

New Mexico Medical Board, Santa Fe, NM

Name and Mailing Address

BHAVIK KUMAR
MONTEFIORE MED CTR
DEPT OF FAMILY MED
3544 JEROME AVE
BRONX, NY 10467-1005

Birth date [redacted]/1985

Primary Office Address

SAME AS MAILING ADDRESS

Phone UNKNOWN

Physician's major professional activity NOT CLASSIFIED

Self-designated practice specialty FAMILY MEDICINE (primary)
UNSPECIFIED (secondary)

Self-designated practice specialties (SDPS) listed on the AMA Physician Profile do not imply recognition or endorsement of any field of medical practice by the Association nor does it imply verification by a member board of the American Board of Medical Specialties (ABMS) or that the physician has been trained or has special competence to practice the SDPS.

AMA membership status NON MEMBER

All information from this point forward is provided by the primary source

Current and/or historical NPI information

National Provider Identifier (NPI)	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
1003197641	09/08/2011	NOT RPTD	NOT RPTD	NOT RPTD	10/17/2015

Current and/or historical medical school

TEXAS TECH UNIVERSITY HEALTH SCIENCE CENTER SCHOOL OF MEDICINE

Degree Awarded: YES

AMA
AMERICAN MEDICAL ASSOCIATION

Degree Year: 2010

Current and/or historical post graduate medical training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME)

Beginning with the 2010 cycle of the National GME Census, post-graduate training segments will include the name of the program attended in addition to the sponsoring institution. Program-level information prior to 2010 will not be available for reporting. Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with the projected date of completion.

Post-graduate training performed at accredited osteopathic institutions or in Canada are updated on the AMA Physician Masterfile only upon verification by the program. US licensing authorities accept graduate medical education from both entities as equivalent to training performed in a US program accredited by ACGME.

If a segment below is indicated as "being re-verified", it typically means that the physician is a current resident and the AMA is confirming with the residency program that the physician is still enrolled - this standard process occurs on an annual basis.

Sponsoring Institution: ALBERT EINSTEIN COLLEGE OF MEDICINE OF YESHIVA UNIVERSITY
Sponsoring State: NEW YORK
Program name: ALBERT EINSTEIN COLLEGE OF MEDICINE PROGRAM
Specialty: FAMILY MEDICINE
Dates: 7/2010 - 7/2013 (Verified)

Specialty Board Certification

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by Joint Commission. The AMA is also an NCQA-approved source for verification of medical school, postgraduate medical training, ABMS Board certification, and Federal DEA registration.

Certifying board: AMERICAN BOARD OF FAMILY MEDICINE
Certificate: FAMILY MEDICINE
Certificate type: GENERAL

Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported Date	Participation Status
MOC+	07/01/2013	n/a	02/15/2016	INITIAL	09/03/2015	Y

For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information. (**) Indicates an expired certificate.

+The above certifying board has implemented standards which specify that the board certification is contingent upon meeting ongoing requirements of Maintenance of Certification (MOC). Only certificates issued by a MOC participating board will reflect a reverification date.

Current and/or historical medical licensure

Jurisdiction	MD / DO	Date Granted	Expiration Date	Status	License Type	Last Reported
New York	MD	03/22/2013	12/31/2016	ACTIVE	UNLIMITED	10/26/2015
Texas	MD	11/07/2014	11/30/2015	ACTIVE	UNLIMITED	11/03/2015
Texas	MD	03/20/2013	04/08/2013	UNKNOWN	RESIDENT	05/02/2013

Action Notifications

To date, there have been no actions reported to the AMA by any US state licensing agency.

To date, there have been no Medicare/Medicaid sanctions reported to the AMA by the Department of Health and Human Services.

To date, there have been no federal sanctions reported to the AMA by any branch of the US military, the Veteran's Administration or the US Department of Justice.

U.S. Drug Enforcement Administration (DEA)

DEA number	Schedule	Expiration Date	Last Reported Date	Address
None	Reported			

Only the last three characters of active DEA numbers are displayed

Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.

ECFMG Certfication

Applicant Number:

The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service online at https://cvsonline2.ecfmg.org/

Profile Information

The content of the AMA Physician Profile is intended to assist with credentialing. An organization's appropriate use of the data contained in the AMA Physician Masterfile meets selected primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission(AAHCC)/Utilization Review Accreditation Commission (URAC). The AMA Physician Masterfile is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

If any of the data in this Profile is believed to be incorrect, please log in to your account on our profiles website, go to the profile manager tab, find the provider for whom you think we have inaccurate information and click on the "Report" button in the "Report a Discrepancy" column. Enter any of the information that you feel needs to be researched. The AMA will contact the primary source of the data to determine which data is correct. We will notify you of the outcome of our research. If any changes are made to the profile we will update the link in profile manager for this provider so that you can access the new, updated information.

If you have any questions or need additional information about the AMA Physician Profile Service, please call (800) 665-2882.

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for: New Mexico Medical Board As of Date:11/13/2015

PRACTITIONER INFORMATION

Name:	Bhavik Kumar
DOB:	[redacted]1985
Medical School:	Texas Tech University Health Sciences Center School of Medicine Lubbock, Texas, UNITED STATES
Year of Grad:	2010
Degree Type:	MD

BOARD ACTIONS

To date, there have been no actions reported to the FSMB

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
NEW YORK	269339	3/22/2013	12/31/2016	11/4/2015
TEXAS	44193			11/2/2015
TEXAS	BP10045440	3/20/2013	4/8/2013	11/2/2015
TEXAS	Q2321	11/7/2014	11/30/2015	11/2/2015

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for:	New Mexico Medical Board	As of Date:11/13/2015
Practitioner Name:	Bhavik Kumar	

ABMS® CERTIFICATION HISTORY

Certifying Board:	American Board of Family Medicine
Certificate:	Family Practice
Certification Type:	General
Certification Status:	Certified
Meeting MOC Requirements:	Yes

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	MOC	07/01/2013		02/15/2016	Initial	10/29/2015

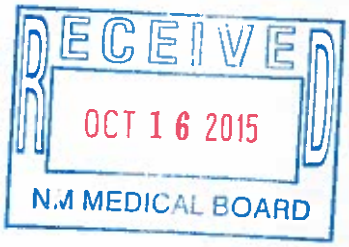
The presence and display of ABMS certification data in no way constitutes any affiliation, association with or endorsement of any advertising, promotion or sponsorship by ABMS, its Member Boards and the Board Certified Physicians listed in this directory. ABMS disclaims any responsibility or affiliation for other data that is provided in the directory that is not ABMS sourced information.

400 FULLER WISER ROAD EULESS, TX 76039 | TEL(817)868 4000 | FAX (817)868 4099

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234

DM

This is to certify that according to the records of the Division of Professional Licensing Services, New York State Education Department Albany, New York, KUMAR BHAVIK
was issued license/certificate number 269339 for the practice of MEDICINE on 03/22/13.



Our records also indicate the following information:
Date of birth: 01/19/85
School attended: TEXAS TECH UNIVERSITY
Date of graduation: 05/22/10
Degree earned: MD

Program was acceptable in accordance with the NYS Regulations of the Commissioner of Education. Requirements met at the time of licensure.

Basis of licensure:

DATE	FLEX1	NBME1	USML1	NBME2	FLEX2	USML2	NBME3	USML3	OTHER
11/11								00082	OOSTX
07/09						00095			
06/08			00091						

EXMS TAKEN=03

A license is valid during the life of the holder unless revoked, annulled or suspended by the Board of Regents. A licensee must register periodically with this Department to practice in this state.

Currently Registered: YES Reg period ends: 12/31/16
Address: 360 E 193RD ST BRONX NY 10458-0000

Disciplinary information: No charges have been preferred against this licensee
Comments:

I, Cathy Hanczaryk, Principal Clerk, Division of Professional Licensing Services of the New York State Education Department, do hereby state that as Principal Clerk of said Division, I have legal custody of the official records of the Division of Professional Licensing Services and to the best of my knowledge, the aforesaid information is true and correct.

SEAL

Cathy Hanczaryk
Principal Clerk

10/08/15

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

WORK EXPERIENCE VERIFICATION

I am applying for a medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB, **2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.**

Bhavik Kumar
Applicant Name

[redacted]

Applicant Signature

03/15 to current
(If be provided)

[redacted]

The section below should be completed by the chief of staff or facility's administrative staff. Letters of Recommendation are ***NOT*** accepted in lieu of this form.

MARVA N. SADLER
Type or Print Name of person completing this form

Director of Clinical Services
Title

Whole Woman's Health of San Antonio
Name of Institution

4025 E. Southcross Blvd. Suite 30
Address

San Antonio, Texas 78222
City / State / Zip

1. This evaluation is based on: ✓ Observation of applicant ___ Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___ Yes ✓ No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___ Yes ✓ No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___ Yes ✓ No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* ✓ Yes ___ No

If not, please provide correct dates: Beginning _____ (Month/Year) Ending _____ (Month/Year)

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

Marva N. Sadler
Printed name of person completing this form

Please affix hospital or notary seal here

Signature of Notary (if applicable) Date

My commission expires: _____

Please note on this form if there is no hospital or notary seal available.

Please return this form directly to the address above.
Thank you for your cooperation.

UA | UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Medical School Verification (UA Form #2)

Applicant: Complete this form as instructed in the left sidebar.
Dean or Designated Med School Official: Complete as instructed in the left sidebar.

Applicant:

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form and a copy of your medical school diploma to the current Dean of your medical school.

Copy this form for multiple schools.

Use the medical board directory located at http://www.fsmb.org/policy/contacts to ensure you list the correct name/address.

Section 1: Applicant Information

Last name: Kumar Suffix:

First name: Bhavik

Middle name:

Name if different when diploma awarded:

Name of medical school: Texas Tech HSC

Date of birth: 1/19/85 Social Security number*: 426772974

*The social security number is to be used for purposes of identification only and may not be used for any other reason.

Waiver for Release of Information: I authorize the medical school listed above to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Dean or a designated official complete Section 2 of this form and seal the copy of my diploma (attached), then return this form, the sealed diploma copy, and a copy of my official transcripts to the Board listed below at the given address.

Board name: New Mexico Medical Board

Mailing address: 2055 S. Pacheco Street Bldg. 400

City/State/Zip: Santa Fe, NM 87505

Applicant signature: [signature] Date: 9/15/15

Dean or Designated Official:

Please complete Section 2 of this form and certify the enclosed copy of the above named applicant's diploma by placing your school seal on it.

Mail the sealed diploma copy and an official copy of the transcripts of the above named physician with this form and any attachments to the state board listed in Section 1.

DO NOT MAIL THIS FORM TO FCVS/FSMB.

If transcripts are not in English, an original, certified, and official English translation is required.

Section 2: Medical School Verification

Medical school name: Texas Tech University HSC

School name if different when the above applicant attended:

Medical school address (including city, state or province, zip code, and country as applicable):

3601 4th St
Lubbock, TX 79430

Hours of undergraduate education required for admission into your school: 4 years

Total weeks of education applicant attended your school: 159

Applicant's attendance dates: From 08/21/2006 to 05/21/2010

Graduation date: 05/22/2010 (indicate N/A if not applicable) Degree: MD (indicate N/A if not applicable)

The questions on the following page apply to unusual circumstances that occurred during any part of the individual's medical education. Please check the appropriate response(s) and provide dates and requested information. "Yes" responses to any of these questions require a copy of explanatory records or a written explanation. Attach additional pages as necessary.

Applicant Name: Bhavik Kumar

1. Do the official records for this individual reflect (an) interruption(s) or extension(s) in his/her medical education? Yes ☐ No ☒

   If yes, please select the reason(s), indicate the dates of the interruption(s) or extension(s), and indicate whether the interruption(s)/ extension(s) was/were approved or unapproved.

	From Month/Year	To Month/Year	Approved	Unapproved
☐ Personal/Family			☐	☐
☐ Academic remediation			☐	☐
☐ Health			☐	☐
☐ Financial			☐	☐
☐ Participation in joint degree program (e.g., MD/PhD)			☐	☐
☐ Participation in non-research special study (e.g., fellowship, international experience)			☐	☐
☐ Other:			☐	☐

2. Do the official records for this individual reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? Yes ☐ No ☒

   If yes, please select the reason(s) for the probation, indicate the date(s) of placement on and removal from probation, and attach documentation/information of the circumstances and outcome(s).

	From Month/Year	To Month/Year
☐ Academic probation		
☐ Probation for unprofessional conduct/behavioral reasons		
☐ Probation for other reason(s) (please specify):		

3. Do the official records for this individual reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? Yes ☐ No ☒

   If yes, please attach documentation/information of the circumstances and outcome(s).

4. Do the official records for this individual reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? Yes ☐ No ☒

   If yes, please attach documentation/information of the circumstances and outcome(s).

5. Do the official records for this individual reflect that there were ever any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? Yes ☐ No ☒

   If yes, please attach documentation/information of the nature of the limitations or special requirements.

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)

Signature: [signature]

Print name: Jayme Darnell

Title: Section Chief

Date: 9/24/15

Phone number: 806-743-2300 Fax number: 806-747-2304

Email: Jayme.Darnell@ttuhsc.edu

Texas Tech University Health Sciences Center

School of Medicine

To All To Whom These Presents May Come, Greetings:
Be It Known That

Bhavik Kumar

having completed the studies and satisfied the requirements for the degree of

Doctor of Medicine

has accordingly been admitted to that Degree with all the honors, rights and privileges belonging thereto.
Issued by the Board of Regents upon recommendation of the faculty,

May twenty-second, A.D. 2010

Chairman–Board of Regents

President

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER

Chancellor

Dean

This is to certify that this document is an exact copy of the diploma issued to Bhavik Kumar from Texas Tech University Health Sciences on May 22, 2010.

Jamara Krause
Registrar

Bhavik Kumar
[redacted] [redacted]-1985

Course Level: Medicine

Current Program
Doctor of Medicine
Program : Medicine
College : School of Medicine
Campus : El Paso HSC
Major : Medicine

Awarded Degree Doctor of Medicine 22-MAY-2010
Primary Degree
Program : Medicine
College : School of Medicine
Campus : El Paso HSC
Major : Medicine

SUBJ	NO.	COURSE TITLE	CREDGRD	PTS	R	C

INSTITUTION CREDIT:

Fall 2006 Medicine

MSCI	5060	Clinically Oriented Ana	9.000	PA	.000
MSCI	5070	Biology Of Cells And Ti	9.000	PA	.000
MSCI	5080	Early Clinical Experien	9.000	PA	.000

	AHRS	EHRS	QHRS	QPTS	GPA
Current	27.000	27.000	0.000	.000	.000
Cumulative	27.000	27.000	0.000	.000	.000

Spring 2007 Medicine

MCBA	5023	Surgical Anatomy	2.000	PA	.000
MSCI	5030	Structure & Funct Maj O	9.000	PA	.000
MSCI	5040	Host Defense	9.000	PA	.000

	AHRS	EHRS	QHRS	QPTS	GPA
Current	20.000	20.000	0.000	.000	.000
Cumulative	47.000	47.000	0.000	.000	.000

********** CONTINUED ON NEXT COLUMN **********

SUBJ	NO.	COURSE TITLE	CREDGRD	PTS	R	C

Institution Information continued:

Fall 2007 Medicine

MSCI	6010	Gen Prin & Integrated N	9.000	PA	.000
MSCI	6020	Multisystem Disorder An	9.000	PA	.000
MSCI	6080	Early Clinical Experien	9.000	PA	.000

	AHRS	EHRS	QHRS	QPTS	GPA
Current	27.000	27.000	0.000	.000	.000
Cumulative	74.000	74.000	0.000	.000	.000

Spring 2008 Medicine

MSCI	6030	Systems Disorders I	9.000	PA	.000
MSCI	6040	Syst Disord II & Lif	9.000	PA	.000

	AHRS	EHRS	QHRS	QPTS	GPA
Current	18.000	18.000	0.000	.000	.000
Cumulative	92.000	92.000	0.000	.000	.000

Fall 2008 Medicine

MFAM	7094	Family Medicine Jr Clks	8.000	PA	.000
MPED	7094	Pediatric Jr Clkship	8.000	PA	.000
MSCI	7091	Continuity Clinic Exper	2.000	PA	.000
MSUR	7093	General Surgery Jr Clks	8.000	PA	.000

	AHRS	EHRS	QHRS	QPTS	GPA
Current	26.000	26.000	0.000	.000	.000
Cumulative	118.000	118.000	0.000	.000	.000

********** CONTINUED ON PAGE 2 **********

Date Issued: 24-SEP-2015 New Mexico Medical Board

Tamara Krauser

Tamara Krauser, Registrar

Bhavik Kumar
[redacted] [redacted]-1985

SUBJ	NO.	COURSE TITLE	CRED	GRD	PTS	R	C

Institution Information continued:

Spring 2009 Medicine

MINT	7093	Internal Medicine JR Cl	8.000	PA	.000	
MOBG	7093	OB/GYN JR Clerkship	8.000	HO	.000	
MPSY	7094	Psychiatry JR Clerkship	8.000	PA	.000	

	AHRS	EHRS	QHRS	QPTS	GPA
Current	24.000	24.000	0.000	.000	.000
Cumulative	142.000	142.000	0.000	.000	.000

Fall 2009 Medicine-Lubbock

MFAM	8061	Family Medicine Sr. Rot	4.000	PA	.000	
MFAM	8061	Family Medicine Sr. Rot	4.000	HO	.000	
MFAM	806A	Family Medicine Precept	4.000	HO	.000	
MINT	806G	MICU/CCU Elective	4.000	HO	.000	
MNEU	8061	Neurology Senior Rotati	4.000	PA	.000	

	AHRS	EHRS	QHRS	QPTS	GPA
Current	20.000	20.000	0.000	.000	.000
Cumulative	162.000	162.000	0.000	.000	.000

.

Spring 2010 Medicine-Lubbock

MINT	816A	Geriatrics	2.000	PA	.000	
MOBG	8061	Ob/Gyn Senior Rotation	2.000	HO	.000	
MPAT	806F	Anatomic and Clinical P	2.000	PA	.000	
MPED	806V	Pediatric Subinternship	4.000	PA	.000	
MSUR	806F	Plastic Surgery Electiv	4.000	HO	.000	

	AHRS	EHRS	QHRS	QPTS	GPA
Current	14.000	14.000	0.000	.000	.000
Cumulative	176.000	176.000	0.000	.000	.000

.

********** CONTINUED ON NEXT COLUMN **********

********** TRANSCRIPT TOTALS **********

INSTITUTION	Ehrs:	176.000	QPts:		0.000
	GPA-Hrs:	0.000	GPA:		0.000
TRANSFER	Ehrs:	0.000	QPts:		0.000
	GPA-Hrs:	0.000	GPA:		0.000
OVERALL	Ehrs:	176.000	QPts:		0.000
	GPA-Hrs:	0.000	GPA:		0.000

********** END OF TRANSCRIPT **********

Date Issued: 24-SEP-2015

Tamara Krauser

Tamara Krauser, Registrar

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Postgraduate Training Verification (UA Form #3)

Applicant: Complete this form as instructed in the left sidebar.
Program Director or Designated Official: Complete as instructed in the left sidebar.

RECEIVED
NOV 13 2015
NM MEDICAL BOARD

Applicant:

This form is not needed if you are using FCVS for credentials verification.

Complete Section 1 and fill in your name at the top of page 2. Type or print legibly.

Send this form to the current Program Director of your postgraduate training program.

Copy this form for multiple training programs.

Use the medical board directory located at http://www.fsmb.org/policy/contacts to ensure you list the correct name/address.

Section 1: Applicant Information

Last name: Kumar Suffix:

First name: Bhavik

Middle name:

Name if different when diploma awarded:

Name of postgraduate training program: Montefiore Medical Center

Date of birth: [redacted]/85 Social Security number* [redacted]

*The social security number is to be used for purposes of identification only and may not be used for any other reason.

Waiver for Release of Information: I authorize the postgraduate training program listed above to provide any and all information pertaining to my medical education at that institution to the Board listed below. I request that the Program Director or a designated official complete Section 2 of this form and send it to the Board listed below at the given address.

Board name: New Mexico Medical Board

Mailing address: 2055 S. Pacheco St. Bldg. 400

City/State/Zip: Santa Fe, NM 87505

Applicant signature: Date: 8/15/15

Dean or Designated Official:

Please complete Section 2. Report incomplete years separately from those that were completed successfully. Report each Internship, Residency, and Fellowship separately.

Use one section per specialty/subspecialty. Provide a schedule of rotations if the specialty/ subspecialty is rotating/ transitional.

Make copies and attach additional pages if necessary.

Send this form to the board listed in Section 1 with any added documentation, if applicable.

DO NOT MAIL THIS FORM TO FCVS/FSMB.

Section 2: Postgraduate Training Verification

Institution name: Montefiore Medical Center
RPSM Family Medicine

Institution address: 3544 Jerome Avenue
Bronx, New York 10467

Institution city / state or province / zip code:

Affiliated medical school name: Albert Einstein College of Medicine

Institution / school name if different when the applicant attended:

Postgraduate year (e.g., 1, 2, 3, etc.): 1 ☐ Internship ☑ Residency ☐ Fellowship

☐ Research ☐ Chief Residency ☐ Other:

Specialty/Subspecialty: Family Medicine

Attendance dates: From 7/1/2010 to 6/30/2012

Successfully completed*? ☑ Yes ☐ No ☐ In progress with expected completion date of

*In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program? Yes

Accredited by: ☑ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Applicant Name: Bhavik Kumar

Postgraduate year (e.g., 1, 2, 3, etc.): 2 ☐ Internship ☑ Residency ☐ Fellowship
☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: Family Medicine

Attendance dates: From 7/1/2011 to 6/30/2012

Successfully completed*? ☑ Yes ☐ No ☐ In progress with expected completion date of _____

*In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program? Yes

Accredited by: ☑ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Postgraduate year (e.g., 1, 2, 3, etc.): 3 ☐ Internship ☑ Residency ☐ Fellowship
☐ Research ☐ Chief Residency ☐ Other: _____

Specialty/Subspecialty: Family Medicine

Attendance dates: From 7/1/2012 to 6/30/2013

Successfully completed*? ☑ Yes ☐ No ☐ In progress with expected completion date of _____

*In each year of training, did the applicant demonstrate sufficient academic and clinical ability to qualify for advancement without conditional or probationary status to the next year and next progressive level of responsibility in a designated specialty program? Yes

Accredited by: ☑ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Please explain any "Yes" response on an additional page or in the blank sidebar area above.

Unusual Circumstances

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☑ No
2. Was this individual ever placed on probation? ☐ Yes ☑ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☑ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☑ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems, or any other reason? ☐ Yes ☑ No

I CERTIFY THAT to the best of my knowledge and belief, the foregoing is a true, accurate, and complete statement of the record of the individual named on this form.

Signature: _____
Print name: Mary Duggan, MD
Title: Program Director
Date: 11/9/15
Phone number: 718-920-5521 Fax number: 718-515-5416
Email: mduggan@montefiore.org

AFFIX INSTITUTIONAL SEAL HERE

(If no seal is available, this form must be notarized.)

ELBA IRIS CARPIO
Notary Public, State of New York
Qualified in Bronx County
No. 01CA6070198
My Commission Expires Feb. 25, 2018